		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039842

Facility Name: CLAREMONT REHAB & LIVING CENTER

Address: 150 N. WEILAND (Number) BUFFALO GROVE (City) 60089 (Zip Code)

County: LAKE

Telephone Number: (847) 465-0200 **Fax #** (847) 465-0400

IDPA ID Number: 36-3976986-60089-0

Date of Initial License for Current Owners: 11/22/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) BRUCE LEDERMAN
(Title) VICE PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	200	Skilled (SNF)	200	73,000	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,000	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			8,959	8,959	8
9	SNF/PED					9
10	ICF	20,426	28,254	2,103	50,783	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,426	28,254	11,062	59,742	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.84%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
OUTPATIENT THERAPY

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/22/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/22/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified _____ and days of care provided 8,959

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTEI # 0039842 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	361,620	44,311	19,937	425,868		425,868	0	425,868			1
2	Food Purchase		327,968		327,968		327,968	(15,203)	312,765			2
3	Housekeeping	233,876	43,635	0	277,511		277,511	0	277,511			3
4	Laundry	88,083	13,766	2,058	103,907		103,907	0	103,907			4
5	Heat and Other Utilities			226,222	226,222		226,222	0	226,222			5
6	Maintenance	69,249	19,539	85,450	174,238		174,238	(4,659)	169,579			6
7	Other (specify):*			33,046	33,046		33,046	0	33,046			7
8	**TOTAL General Services**	752,828	449,219	366,713	1,568,760	0	1,568,760	(19,862)	1,548,898			8
	B. Health Care and Programs											
9	Medical Director	0		47,000	47,000		47,000	0	47,000			9
10	Nursing and Medical Records	3,055,770	223,047	81,784	3,360,601		3,360,601	0	3,360,601			10
10a	Therapy	583,947	2,146	328	586,421		586,421	0	586,421			10a
11	Activities	142,937	9,367	50,000	202,304		202,304	0	202,304			11
12	Social Services	56,470		8,548	65,018		65,018	0	65,018			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			237	237		237	0	237			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	3,839,124	234,560	187,897	4,261,581	0	4,261,581	0	4,261,581			16
	C. General Administration											
17	Administrative	244,686		0	244,686		244,686	0	244,686			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			208,361	208,361		208,361	14,733	223,094			19
20	Dues, Fees, Subscriptions & Promotions			162,242	162,242		162,242	(126,177)	36,065			20
21	Clerical & General Office Expenses	258,316	40,491	77,743	376,550		376,550	(53,508)	323,042			21
22	Employee Benefits & Payroll Taxes			667,018	667,018		667,018	0	667,018			22
23	Inservice Training & Education			8,075	8,075		8,075	0	8,075			23
24	Travel and Seminar			842	842		842	0	842			24
25	Other Admin. Staff Transportation			4,876	4,876		4,876	0	4,876			25
26	Insurance-Prop.Liab.Malpractice			109,360	109,360		109,360	0	109,360			26
27	Other (specify):*			55,615	55,615		55,615	(55,615)	0			27
28	**TOTAL General Administration**	503,002	40,491	1,294,132	1,837,625	0	1,837,625	(220,567)	1,617,058			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,094,954	724,270	1,848,742	7,667,966	0	7,667,966	(240,429)	7,427,537			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER #0039842 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			98,665	98,665		98,665	317,633	416,298			30
31	Amortization of Pre-Op. & Org.			6,249	6,249		6,249	14,039	20,288			31
32	Interest			75,616	75,616		75,616	1,075,938	1,151,554			32
33	Real Estate Taxes				0		0	172,103	172,103			33
34	Rent-Facility & Grounds			1,560,000	1,560,000		1,560,000	(1,560,000)	0			34
35	Rent-Equipment & Vehicles			36,679	36,679		36,679	0	36,679			35
36	Other (specify):* OFFICE			94,725	94,725		94,725	0	94,725			36
37	**TOTAL Ownership**			1,871,934	1,871,934	0	1,871,934	19,713	1,891,647			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		323,270	40,017	363,287		363,287	0	363,287			39
40	Barber and Beauty Shops			3,642	3,642		3,642	0	3,642			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			109,500	109,500		109,500	0	109,500			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	323,270	153,159	476,429	0	476,429	0	476,429			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,094,954	1,047,540	3,873,835	10,016,329	0	10,016,329	(220,716)	9,795,613			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,395)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(999)	30		9
10	Interest and Other Investment Income	(5,813)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,808)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(2,368)	20		17
18	Fines and Penalties	(1,365)	21		18
19	Entertainment	0	20		19
20	Contributions	(8,857)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(55,615)	27		24
25	Fund Raising, Advertising and Promotional	(109,889)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(5,063)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(56,802)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (261,974)		$ 0	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	41,258		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 41,258		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (220,716)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

CLAREMONT REHAB & LIVING CENTER

ID# 0039842

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ -4659	6	1
2	MARKETING SALARY	(52,143)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(56,802)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(15,203)	0	0	0	0	0	0	0	0	0	0	(15,203)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(4,659)	0	0	0	0	0	0	0	0	0	0	(4,659)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(19,862)	0	0	0	0	0	0	0	0	0	0	(19,862)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	14,733	0	0	0	0	0	0	0	0	0	14,733	19
20	Fees, Subscriptions & Promotions	(126,177)	0	0	0	0	0	0	0	0	0	0	(126,177)	20
21	Clerical & General Office Expenses	(53,508)	0	0	0	0	0	0	0	0	0	0	(53,508)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(55,615)	0	0	0	0	0	0	0	0	0	0	(55,615)	27
28	**TOTAL General Administration**	(235,300)	14,733	0	0	0	0	0	0	0	0	0	(220,567)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(255,162)	14,733	0	0	0	0	0	0	0	0	0	(240,429)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(999)	318,632	0	0	0	0	0	0	0	0	0	317,633	30
31	Amortization of Pre-Op. & Org.	0	14,039	0	0	0	0	0	0	0	0	0	14,039	31
32	Interest	(5,813)	1,081,751	0	0	0	0	0	0	0	0	0	1,075,938	32
33	Real Estate Taxes	0	172,103	0	0	0	0	0	0	0	0	0	172,103	33
34	Rent-Facility & Grounds	0	(1,560,000)	0	0	0	0	0	0	0	0	0	(1,560,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(6,812)	26,525	0	0	0	0	0	0	0	0	0	19,713	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(261,974)	41,258	0	0	0	0	0	0	0	0	0	(220,716)	45

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
BRUCE LEDERMAN	47.50	WINDSOR MANOR	PALOS HILLS	WINDSOR MGMT		MANAGEMENT
HAROLD LEDERMAN	47.50	THE CLAREMONT OF LEE COUNTY	DIXON	FREEDOM HOME	BUFFALO GROVE	HOME CARE
ANREA WEITZBERG	5.0			CARE		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 1,560,000	WINDSOR HEALTHCARE MANAGEMENT ASSOC.		$	$ (1,560,000)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V	19	PROFESSIONAL FEES		" " "		14,733	14,733	6
7	V	30	DEPRECIATION		" " "		318,632	318,632	7
8	V	31	AMORTIZATION		" " "		14,039	14,039	8
9	V	32	INTEREST		" " "		1,081,751	1,081,751	9
10	V	33	REAL ESTATE TAX EXPENSE		" " "		172,103	172,103	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,560,000			$ 1,601,258	$ * 41,258	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTE # 0039842 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	BRUCE LEDERMAN	VICE PRESIDENT	ADMINISTRATIVE						$ 0		1
2	ALAN BURACK		MARKETING	0.00				SALARY	52,143	17-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 52,143		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTEI # 0039842 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	PRUDENTIAL			MORTGAGE			$	$			$ 1,081,751	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LASALLE BANK		X	LINE OF CREDIT	INTEREST			1,021,313		PRIME +	73,303	6
7	UPAC		X	INSURANCE FINANCING				0			2,313	7
8												8
9	TOTAL Facility Related						$ 0	$ 1,021,313			$ 1,157,367	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 0	$ 1,021,313			$ 1,157,367	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	172,103	2
3. Under or (over) accrual (line 2 minus line 1).	$	172,103	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	0	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	172,103	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	109,416	8
	1997	137,272	9
	1998	153,789	10
	1999	165,681	11
	2000	172,103	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CLAREMONT REHAB & LIVING CENTER COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0039842

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-33-404-140	NURSING HOME	$ 172,103.12	$ 172,103.12
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 172,103.12	$ 172,103.12

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 86,000 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	4.1 ACRES	1994	$ 551,078	1
2					2
3	TOTALS	#VALUE!		$ 551,078	3

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	200		1994	1994	$ 8,490,995	$ 223,103	39	$ 217,718	$ (5,385)	$ 1,623,682	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	EXTERIOR SIGN			1995	3,113	80	15	80		550	9
10	NURSING STATION			1995	2,634	68	39	68		456	10
11	CONDENSOR			1995	11,363	291	39	291		1,855	11
12	SODING, PLANTING			1995	1,350	35	39	35		217	12
13	REPLACE SWITCHES			1995	2,732	70	39	70		429	13
14	INSTALLED OUTLETS			1995	1,651	42	39	42		254	14
15	INSTALLED CIRCUITS			1996	2,360	61	39	61		318	15
16	SHRUBS			1996	5,480	366	15	366		2,012	16
17	CEILING FIRE DAMPERS			1997	11,500	295	39	295		1,315	17
18	LEAD SHOWER PANS			1997	6,875	176	39	176		726	18
19	HEATER REPAIR			1997	20,316	521	39	521		2,149	19
20	TILE			1997	4,890	125	39	125		505	20
21	CERAMIC TILE			1998	7,335	188	39	188		745	21
22	CARPETING			1998	25,777	661	39	661		2,452	22
23	WALL REPAIR/PAINT			1998	53,734	1,378	39	1,378		4,398	23
24	EXIT SIGNS			1998	1,860	48	39	48		154	24
25	REPLACE SIDEWALK, ASPHALT SEALING			1998	8,147	543	15	543		1,900	25
26	LANDSCAPE			1998	22,400	1,494	15	1,494		5,228	26
27	GAZEBO, PLAYGROUND EQUIPMENT			1998	32,800	2,188	15	2,188		7,656	27
28	ELEVATOR REPAIRS			1999	43,763	1,122	39	1,122		2,572	28
29	SIDEWALK			1999	4,900	327	15	327		817	29
30	LIGHTING/ SENSORS/OUTLETS			2000	45,308	1,647	27.5	1,647		3,226	30
31	ELEVATOR REPAIR			2000	62,821	2,284	27.5	2,284		2,936	31
32	SEWER REPAIR / SHOWER DRAIN REPAIR			2001	4,100	138	27.5	138		138	32
33	HVAC / AIR UNIT REPAIR			2001	20,061	171	27.5	171		171	33
34	HOT WATER TANK			2001	36,873	795	27.5	795		795	34
35	KIDNEY DIALYSIS ROOM			2001	59,646	1,186	27.5	1,186		1,186	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,994,784	$ 239,403		$ 234,018	$ (5,385)	$ 1,668,842	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 456,439	$ 69,490	$ 46,045	$ (23,445)	8/15 YRS	$ 188,764	71
72	Current Year Purchases	70,147	11,100	3,507	(7,593)	10/YRS	3,507	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTY	1,295,212	95,529	129,521	33,992	10 YRS	906,647	74
75	TOTALS	$ 1,821,798	$ 176,119	$ 179,073	$ 2,954		$ 1,098,918	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		FORD VAN	1998	$ 16,033	$ 1,775	$ 3,207	$ 1,432		$ 12,828	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 16,033	$ 1,775	$ 3,207	$ 1,432		$ 12,828	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,383,693	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 417,297	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 416,298	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (999)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,780,588	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 19,621 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATOR	99-HONDA ACCORD	$	$ 4,096	17
18		98-HONDA ACCORD		5,265	18
19	PATIENTS	99-14-PASSNGR BUS		7,697	19
20					20
21	TOTAL		$	$ 17,058	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 105	$		$ 105	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			4,565			4,565	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			54			54	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				321,315		321,315	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Med Supp, Lab, Rentals and other Other (specify): services	39-2 & 3					37,248		37,248	13
14	TOTAL			$		$ 4,724	$ 358,563		$ 363,287	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER **#** 0039842 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 386,294	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 120,000)	2,414,721		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	117,673		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	830,995		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,749,683	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	503,789		15
16	Equipment, at Historical Cost	542,619		16
17	Accumulated Depreciation (book methods)	(431,733)		17
18	Deferred Charges	41,725		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 656,400	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,406,083	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,341,545	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,021,313		29
30	Accrued Salaries Payable	223,518		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,626		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	4,475		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,616,477	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	234,596		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 234,596	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,851,073	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,555,010	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,406,083	$ 0	48

***(See instructions.)**

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,202,455	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,202,455	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	355,754	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(3,199)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 352,555	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,555,010	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,021,070	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,021,070	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	329,565	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 329,565	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,130	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	8,782	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	5,240	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 15,152	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,813	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,813	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Commissions	483	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 483	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,372,083	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,568,760	31
32	Health Care	4,261,581	32
33	General Administration	1,837,625	33
	B. Capital Expense		
34	Ownership	1,871,934	34
	C. Ancillary Expense		
35	Special Cost Centers	366,929	35
36	Provider Participation Fee	109,500	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,016,329	40
41	**Income before Income Taxes (line 30 minus line 40)****	355,754	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 355,754	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,040	2,177	$ 70,921	$ 32.58	1
2	Assistant Director of Nursing	1,960	2,008	56,959	28.37	2
3	Registered Nurses	28,490	30,205	763,015	25.26	3
4	Licensed Practical Nurses	21,225	22,600	462,972	20.49	4
5	Nurse Aides & Orderlies	114,470	122,673	1,438,370	11.73	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	15,091	30,946	432,841	13.99	7
8	Rehab/Therapy Aides	9,993	11,578	151,106	13.05	8
9	Activity Director					9
10	Activity Assistants	13,791	14,652	142,937	9.76	10
11	Social Service Workers	3,747	4,030	56,470	14.01	11
12	Dietician					12
13	Food Service Supervisor	4,160	4,416	81,499	18.46	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,338	33,133	280,121	8.45	15
16	Dishwashers					16
17	Maintenance Workers	4,248	4,481	69,249	15.45	17
18	Housekeepers	25,897	27,756	233,876	8.43	18
19	Laundry	11,355	11,988	88,083	7.35	19
20	Administrator	2,056	2,356	100,137	42.50	20
21	Assistant Administrator	4,369	4,499	37,104	8.25	21
22	Other Administrative	4,420	4,420	107,445	24.31	22
23	Office Manager					23
24	Clerical	13,954	14,432	258,316	17.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,883	4,330	55,560	12.83	31
32	Other Health Care(specify)					32
33	Other(specify) see attached	8,443	8,733	207,973	23.81	33
34	TOTAL (lines 1 - 33)	324,930	361,413	$ 5,094,954 *	$ 14.10	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 12,368	1-3	35
36	Medical Director	O	47,000	9-3	36
37	Medical Records Consultant	N	4,032	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	3,600	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	8,548	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 75,548		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,722	$ 44,784	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,722	$ 44,784		53

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
L PUTZ	ADMINTRT	0.00%	$ 71,016
L CLARKE	ADMINTRT	0.00%	29,121
L SHAPIRO	ASST ADM	0	37,104
OTHER ADMINISTRATIVE		0	107,445
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 244,686

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		208,361
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 208,361

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,971
Unemployment Compensation Insurance	38,153
FICA Taxes	377,253
Employee Health Insurance	175,581
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	2,370
EMPLOYEE PHYSICAL EXAMS	690
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 667,018

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	22,093
Health Care Worker Background Check	1,320
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	114,952
TRUST FEES/FRANCHISE TX/ETC	2,368
CONTRIBUTIONS	8,857
DUES & SUBSCRIPTIONS	11,927
LICENSES & PERMITS	725
TRUST FEES/FRANCHISE TX/ETC	(2,368)
Less: Public Relations Expense	(8,857)
Non-allowable advertising	(109,889)
Yellow page advertising	(5,063)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,065

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	842
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 842

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINTING & DECORAT	2000	$ 5,325	3	$	$	$ 887	$ 1,775	$ 1,775	$ 888	$	$	$
2	PAINTING & DECORAT	2001	7,721	3				1,287	2,574	2,574	1,286		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 13,046		$	$	$ 887	$ 3,062	$ 4,349	$ 3,462	$ 1,286	$	$

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER **#** 0039842 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ILLINOIS COUNCIL ON LONG TERM CARE $11,350

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 211 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 109,500
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? YES Indicate the amount. $ 10,395

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: CLAREMONT REHAB & LIVING CENTER #0039842 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	12,368	
	REPAIRS & MAINTENANCE		7,569	
			0	19,937
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,058	
			0	2,058
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		77,324	
	ELECTRICITY		116,437	
	WATER		27,121	
	CABLE TV - LOBBY		5,340	
			0	226,222
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		15,181	
	PAINTING & DECORATING		15,708	
	BUILDING REPAIRS		258	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		38,882	
	ELEVATOR MAINTENANCE & REPAIR		12,007	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,180	
	FIRE SERVICE		2,234	
			0	
			0	
			0	85,450
7	**OTHER**			
	SCAVENGER		32,905	
	SECURITY SERVICE		141	33,046
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	47,000	47,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	44,784	
	LABORATORY & XRAY EXPENSE		19,168	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	6,375	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,032	
	PHARMACY CONSULTANT	XVIII B 39-2	3,600	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	PROGRAM CONSULTANT		3,825	
			0	81,784
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		328	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTAI	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	328
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
	CLERGY		50,000	50,000
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	8,548	
			0	8,548
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER **#0039842** **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		237	237
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	35,155	
	ADMINISTRATIVE CONSULTANTS	XIX C		
	PROFESSIONAL FEES	XIX C	173,206	
			0	208,361
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	109,889	
	EMPLOYEE WANT ADS	XIX F	22,093	
	CONTRIBUTIONS	VI 20 XIX F	3,107	
	DUES & SUBSCRIPTIONS	XIX F	11,927	
	LICENSES & PERMITS	XIX F	725	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	5,063	
	TRUST FEES/ FRANCHISE TAX.ETC	VI 17 XIX F	2,368	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	5,750	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,320	162,242
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		216	
	EQUIPMENT REPAIR & MAINTENANCE		10,278	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES	VI 18	1,365	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		4,778	
	TELEPHONE		34,583	
	MESSENGER SERVICE		0	
	COMPUTER MAINTENANCE		26,523	77,743

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	377,253	
	UNEMPLOYMENT COMPENSATION	XIX D	38,153	
	WORKERS COMPENSATION INSURANC	XIX D	72,971	
	HOSPITALIZATION INSURANCE	XIX D	175,581	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,370	
	EMPLOYEE PHYSICAL EXAMS	XIX D	690	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	667,018
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		8,075	8,075
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	842	
			0	
			0	842
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		4,876	4,876
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		109,360	109,360
27	**OTHER**			
	BAD DEBTS	VI 24	55,615	
				55,615

GRAND TOTAL COLUMN 3 OTHER 1,848,742

CLAREMONT REHAB & LIVING CENTER
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	327,968	PATIENT MEALS	179226
LESS SALES TAX	(4,808)	ADD EMPLOYEE MEALS	0
NET FOOD	332776	TOTAL MEALS/YEAR	179226
TOTAL PATIENT CENSUS	59,742	NET FOOD	332776
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	179226
TOTAL PATIENT MEALS	179226	COST PER MEAL	1.86
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		